## PATIENT REGISTRATION

ID: _____          Chart ID: _____

First Name: _____          Last Name: _____          Middle Initial: _____

Patient Is:  ☐ Policy Holder                    Preferred Name: _____
             ☐ Responsible Party

**Responsible Party (if someone other than the patient)**

First Name: _____          Last Name: _____          Middle Initial: _____

Address: _____          Address 2: _____

City, State, Zip: _____                              Pager: _____

Home Phone: _____     Work Phone: _____     Ext: _____     Cellular: _____

Birth Date: _____          Soc Sec: _____          Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient    ○ Primary Insurance Policy Holder    ○ Secondary Insurance Policy Holder

**Patient Information**

Address: _____          Address 2: _____

City: _____          State / Zip: _____   _____          Pager: _____

Home Phone: _____     Work Phone: _____     Ext: _____     Cellular: _____

Sex:  ○ Male    ○ Female          Marital Status: ○ Married   ○ Single   ○ Divorced   ○ Separated   ○ Widowed

Birth Date: _____          Age: _____     Soc. Sec: _____          Drivers Lic: _____

E-mail: _____          ☐ I would like to receive correspondences via e-mail.

—————  Section 2  —————                                —————  Section 3  —————

Employment Status:  ○ Full Time   ○ Part Time   ○ Retired          Additional Comments:

Student Status:  ○ Full Time   ○ Part Time

Medicaid ID: _____          Pref. Dentist: _____

Employer ID: _____          Pref. Pharmacy: _____

Carrier ID: _____          Pref. Hyg.: _____

**Primary Insurance Information**

Name of Insured: _____          Relationship to Insured: ○ Self   ○ Spouse   ○ Child   ○ Other

Insured Soc. Sec: _____          Insured Birth Date: _____

Employer: _____          Ins. Company: _____

  Address: _____              Address: _____

  Address 2: _____              Address 2: _____

  City,State,Zip: _____              City,State,Zip: _____

Rem. Benefits: _____ .00     Rem. Deduct: _____ .00

**Secondary Insurance Information**

Name of Insured: _____          Relationship to Insured: ○ Self   ○ Spouse   ○ Child   ○ Other

Insured Soc. Sec: _____          Insured Birth Date: _____

Employer: _____          Ins. Company: _____

  Address: _____              Address: _____

  Address 2: _____              Address 2: _____

  City,State,Zip: _____              City,State,Zip: _____

Rem. Benefits: _____ .00     Rem. Deduct: _____ .00